# Access to Health Insurance Invoice Process

## Invoicing Guidelines

- The Department will send the premium payment reimbursement directly to the Insurance Company. The Insurance Company collects the rest of the premium payment in accordance with their current protocol.

- The Department will pay Insurance Vendors prospectively for coverage of eligible Access to Health Insurance program participants. If a Vendor covers an eligible participant under the Access to Health Insurance program prior to sending an invoice, the Department will consider the invoice valid and pay retroactively for covered dates up to the date the participant was eligible with the Department.

- The Department has provided an example of an invoice. As an approved Vendor, you are welcome to create a template that contains the same data elements or use the invoice provided by the Department. Submit all invoices to the Department by mail.

- A Vendor must submit an invoice to the Department by the 20$^{th}$ of every month in order for the Department to pay coverage for the next month.

- If a participant is no longer eligible for the Access to Health Insurance program, the Department will notify the Vendor by phone or mail within three business days of receipt of an invoice.

- Vendors who are not an approved Vendor with the Access to Health Insurance program will not receive reimbursement premium payments. Mailed invoices will be returned with a denial letter within three business days.

- When a Vendor submits an invoice to the Department that has an ineligible participant listed on it, the Department will send the Vendor written notification of the ineligibility and payment will be denied.

- In the case the Department overpays an approved Vendor, the Department requests reimbursement to the Department by crediting the next month's invoice. The Department cannot receipt money from a vendor for this program. Should an invoice reflect a negative balance, the Department requests vendors continue submitting the invoice reflecting the negative balance.

- In the case the Department fails to pay the correct amount on an invoice to the Vendor, the Department will reimburse the Vendor within three business days.

# Invoice Walkthrough

1. The Insurers Company Name is the name of the Insurance Company listed on the program agreement and enrollment material. This information must be filled out to process an invoice.

| **Insurers Company Name:** | |
|---|---|
| Street Address | **Phone:** 123-456-7890 |
| Address 2 | **Fax:** 123-456-7890 |
| City, ST ZIP Code | **E-mail:** insurer@here.com |

2. The Statement number is the number that will help both the Department and the Insurance Company track the invoices sent for reimbursement. The Statement number consists of a four letter combination of your insurance company name and the month and year the statement is being sent to the Department. The Department will send you the statement number included with your Access to Health Insurance program Vendor approval letter.

   The Date field is the date you are submitting your invoice to the Department.

   The Vendor ID # is the Insurance Company Federal Tax ID number, which is the same number on the enrollment materials you are submitting.

| | |
|---|---|
| **Statement #:** | Insu0304 |
| **Date:** | April 20, 2004 |
| **Vendor ID #** | Insurer Tax ID Number |

3. This address is where you must send all invoices for reimbursement.

| | |
|---|---|
| **Bill To:** | Idaho Department of Health and Welfare<br>Adult & Children's Health Insurance Unit<br>150 Shoup Ave, Suite #5<br>Idaho Falls, Idaho 83402-3653 |

4. The Billing Coverage date is the date you are asking for a premium reimbursement payment to be paid for an eligible participant. (Example: If a participant is eligible for the Access to Health Insurance program, the vendor submits an invoice by January 20th for a payment to be authorized for the month of February.)

| **Billing Coverage Date** |
|---|
| 3/1/2004 |
| 3/1/2004 |

5. The Participant Policy Number is the insurance policy number the Insurance Company has for the Participant.

| Participant Policy Number |
|---|
| Insurers # |
| Insurers # |

6. The Participant Name is the name of the eligible participant enrolled in the Access to Health Insurance program. Every reimbursement premium assistance payment must match to an eligible participant. Please list the participant first name, middle initial and last name.

| Participant Name |
|---|
| Jane M. Doe |
| Joe D. Bunn |

7. The Department assigns a participant an ID #. The Vendor will receive this number from the Insurance Representative. This is an important identification number for the Department to track eligible participants.

| Participant DHW ID# |
|---|
| 000012348 |
| 000012345 |

8. The Participant premium amount is the amount each participant pays for insurance coverage with your Insurance Company. This is the total amount owed for this participant, including the amount paid by the employer or another third party. (Example: It will cost the employee $400 to place a child on the insurance. This is the amount you enter in this column.)

| Participant Premium |
|---|
| $ 400.00 |

9. The Employer Premium amount is the amount paid by the employer towards the participant's premium amount. If there is no employer portion, enter $0.00. (Example: The participant cost is $400. The employer pays $200 towards the participant's premium. Enter amount in this column.)

| Employer Premium |
|---|
| $ 200.00 |

10. The Participant Premium amount is the amount the employee will owe or the family owes for the participant. (Example: The participant cost is $400. The employer pays $200 towards the participant's premium, and the employee's premium is $200. Enter $200 in this column.)

| Participant Premium |
|---|
| $200.00 |

11. The Access to Health Insurance program Reimbursement Amount is the amount the Department pays towards the eligible participant's premium. The Department will only reimburse payment up to $100 per participant per month and up to $500 per family per month. Please ensure your billing office follows these guidelines to avoid the Department sending a denial for payment. (Example: The participant cost is $400. The employer pays $200 towards the participant's premium. The employee's premium is $200. The Department pays $100 for this participant. Enter the amount up to $100 per participant in this column). Vendors may only charge the actual cost of the premium for each participant. The $100 is the maximum amount the Department will pay.

| Access to Health Insurance program Reimbursement Amount |
|---|
| $100.00 |

12. Total the final column "Access to Health Insurance program Reimbursement Amount" before submitting the invoice to the Department.

13. Fill out the "Remit Payment To" box in accordance with the name on the program agreement.

# Invoice Example:

## Insurer's Company Name

Street Address
Address 2
City, ST ZIP Code

**Phone:** 123-456-7890
**Fax:** 123-456-7890
**E-mail:** insurer@here.com

### *Reimbursement for Access to Health Insurance Premium Payment*

**Statement #:** Insu0304
**Date:** January 14, 2005
**Vendor ID #** Insurer Tax ID Number

**Bill To:** Idaho Department of Health and Welfare
Adult & Children's Health Insurance Unit
150 Shoup Ave, Suite #5
Idaho Falls, Idaho 83402-3653

| Billing Coverage Date | Participant Policy Number | Participant Name | Participant DHW ID# | Participant Premium | Employer Premium | Employee Premium | Reimbursement Amount |
|---|---|---|---|---|---|---|---|
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| | | | | | **Total** | | $ - |

| REMIT PAYMENT TO: |
|---|
| Insurer Name: |
| Attention: |
| Payment Address: |
| City, State, Zip Code |